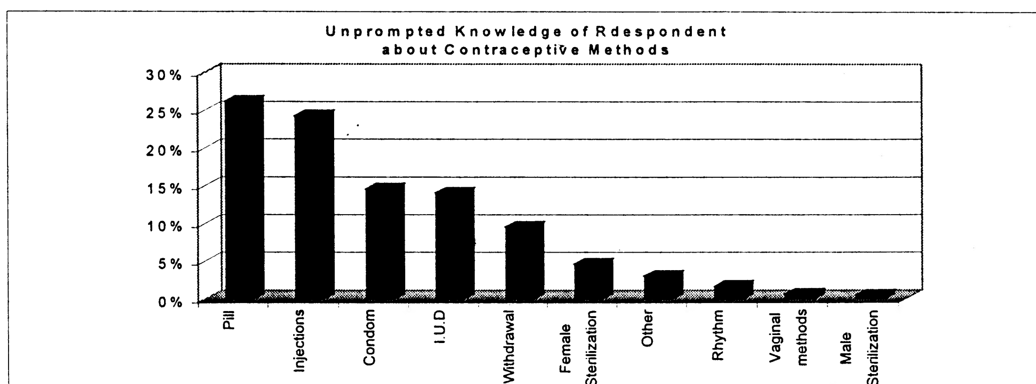
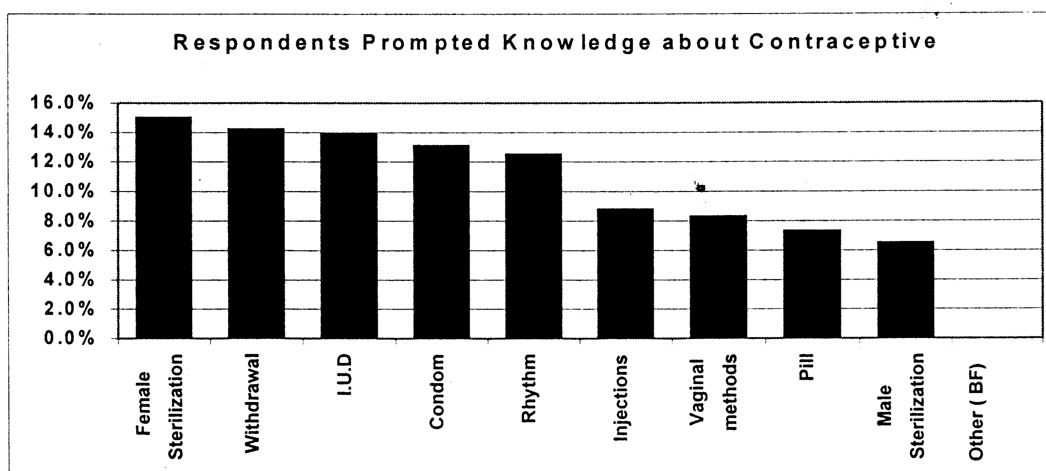
Many women were aware of pills and injections, and were able to cite them as methods of contraception without prompting. Fewer women were able to cite IUCDs and condoms as contraceptives. At the time of the survey, IbnSina clinics provided pills, injections and condoms as FP methods. The unprompted knowledge would seem to be linked with the methods that were currently available.



With prompting, the numbers of women who recognized these methods rose, with a higher rise in those who recognized the surgical methods of contraception. Surgical methods were previously available in Afghanistan and the rise in prompted knowledge would indicate familiarity with this method from previous times or from migration experiences to Pakistan and Iran.

Withdrawal is accepted in muslims and is practiced by a proportion of the people.

The fact that breast feeding protects against pregnancy, seems to be known to some of the women and practiced. The issue of the type of breast feeding, e.g. exclusive breast feeding was not explored. The fact that shortly after start of menstrual cycle after delivery, the risk of pregnancy increases needs to be brought out in education of mothers.



This knowledge of specific method does not signify approval of that method nor any intention to use that method or any other method.

Contraceptive Use

In this survey information was collected on the ever users and current users of contraceptive methods. Current user was defined as the woman that uses a contraceptive method at the time of interview. It must be noted that no data were collected to determine the continuity of the use.

Contraceptive Ever Users

Questions on ever use of both clinical and natural methods of contraception were asked. **Pills in clinical methods were used in most instances followed by injections and condoms. Withdrawal is a common practice and most commonly natural method practiced.** Both clinical and natural methods have ever used in our clinic catchment areas. In natural method withdrawal is high. This method has a very high failure rate, but is significant as widely practiced by Muslims should be kept in mind.

Table 3: Contraceptive methods ever used

Method	Pills	Withdrawal	Injections	Condom	Breast feeding	Rhythm	vaginal
Percentage	28%	26%	15%	11%	11%	2%	1%

Contraceptive Current Users

IbnSina provides child spacing services in all MCH health facilities since its activity started. Initially pills and condoms were provided. Late in 1999, injections were also introduced to widen the range of contraceptives.

Breast-feeding, withdrawal, pills and injections are the main types of contraception practiced by women. The rate of failure is very high in natural methods. We should aim to shift natural method users to the clinical methods. Educate people regarding clinical methods of contraception and their availability should be confirmed.

Table 3: Contraceptives users by type

Methods	Frequency	Relative Frequency
Natural methods		
Breast Feeding	69	14.4%
Withdrawal	57	11.9%
Rhythm	5	1.0%
Clinical Methods		
Pill	59	12.3%
Injections	50	10.4%
I.U.D	18	3.8%
Condom	14	2.9%
Female Sterilization	2	0.4%
Vaginal methods	1	0.2%
Male Sterilization	0	0.0%
Not using any method	204	42.6%

Non Users of Contraceptives

Fifty two percent of women interviewed were not using any method of contraception. This category includes those who had just been married, had low

parity, had less than desired number of children or want a son. A substantial proportion of the non-users depend on lactation as a method to avoid pregnancy.

However, the program should provide more information on natural methods and particularly on the role of breast-feeding, its importance during the 6 months after delivery and the risk of pregnancy involved during the breast-feeding after the start of a normal menstrual cycle.

Table 4: Reasons for not using contraceptives

Reasons for not using contraceptives	Frequency	Relative Frequency
Pregnant	94	31%
Want more children	76	25.5%
Protected by breast feeding	30	10.1%
Religious/ Allah's will	24	8%
Husband or family opposed	16	5.3%
Fear of side effects	12	4%
Able to naturally space children	11	3.6%
No knowledge of family planning	9	3%
Family planning not available	7	2.3%
Husband absent	5	2%
Menstruation has stopped	5	2%
Other	4	1.3%
Side effects in the past	3	1%
Just never done it/too lazy	1	0.3%
Perceived sterile	1	0.3%

Opinion of couples for use of contraceptives

All surveyed women, whether they were users or non users were asked about their approval and disapproval regarding using of family planning methods by couples. **Most of them were in favor of family planning. Less than 17 percent were against it.**

Table 5: Approval and disapproval on use of contraceptives

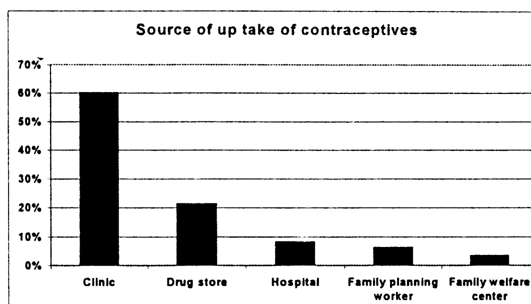
Subject	Frequency	Relative Frequency
Approval	431	75%
Disapproval	97	17%
Didn't Know	45	8%
Total	**573**	**100%**

The main reasons for approval was with less number of children and smaller family the better the life. A few mentioned health reasons for spacing the child bearing.

The main reasons for disapproving child spacing were **religion believes** (44%), health problems (34%), and side effect of contraceptives (6%)

Availability of Child Spacing Services

The availability of child spacing services within the access of clients plays a vital role in increasing the uptake of contraceptives. In the child spacing program it is necessary that arrangements should be made to provide contraceptive services through various outlets such as hospitals, clinics, basic health center, drug store, community worker and others.



The major source of supply for child spacing was health facilities. This result was expected as the survey cites were near our health facilities. The graph shows the main source of child spacing methods.

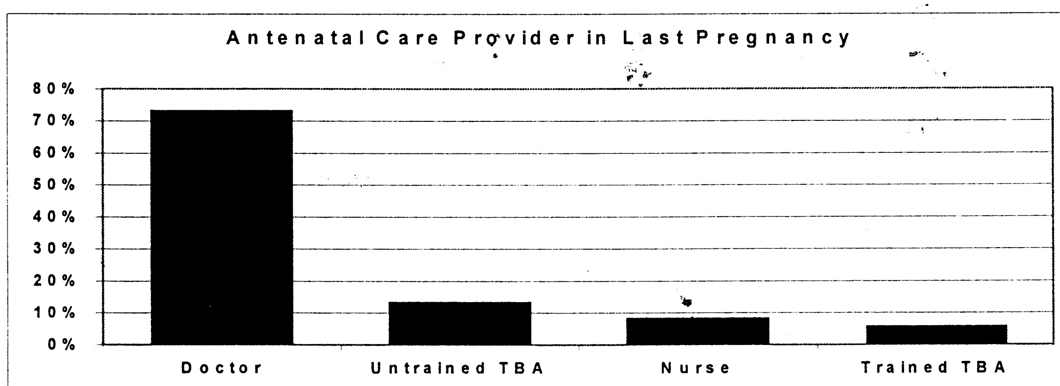
Section III

Mother and Child Health Care

The main objective of the maternal health care is to safeguard the health of mothers. The services are provided before, during and after the childbirth.

Antenatal Care

Doctors provided the highest number of antenatal care, most probably by doctors of our MCH health facilities near to the site of interview. The next group of antenatal care providers is untrained TBA's. IbnSina at present has trained TBA's around the catchment area of its 4 MCH clinics in Nangarhar region. This is the reason for low number antenatal care provided by trained TBA's.



Nurses are trained personnel and have a background of mother care. This group also needs refresher training for safe delivery.

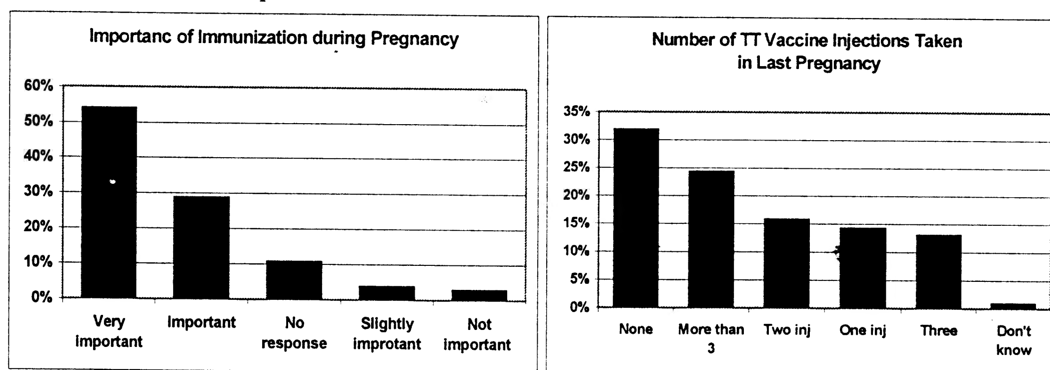
The highest numbers of the surveyed women were provided more than three antenatal cares during the last pregnancy. Most of the cases had at least one or more than one antenatal visit. 36% of mothers had at least 2 antenatal visits in the last pregnancy.

This is probably higher than the normal in Afghanistan and is a reflection of the fact that the respondents were from around the clinic.

Table 6: Antenatal visit by % mothers

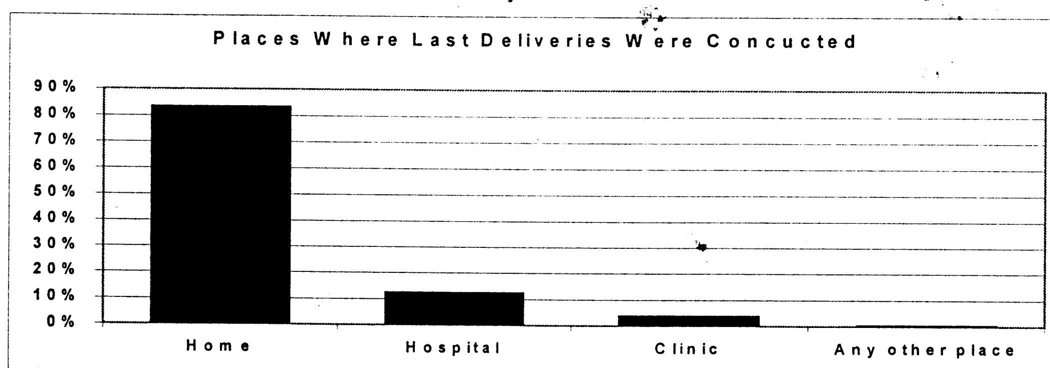
No AN Visits	1 AN Visit	2 AN Visits	3 AN Visits	>3 AN Visits
30%	22%	14%	10%	12%

As shown in the graph below immunization during pregnancy is considered very important for the majority of women interviewed. Very few cases were against the immunization concept.



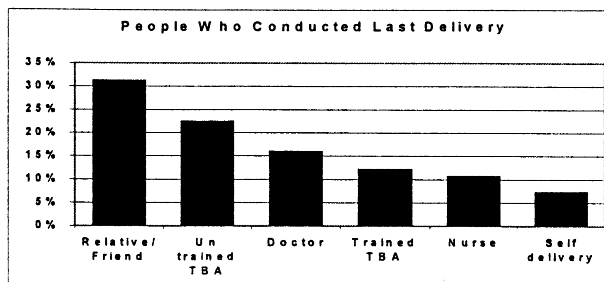
The number of women taken TT vaccine is very high as considered with national figures . It may be due to availability of services and education of mothers during antenatal visits. Only 30% of women had not taken any dose of TT vaccine. More than 25% cases have had 3 or more injections in last pregnancy. It may be during last few pregnancies as in one pregnancy it is impossible to take more than 2 injection due to dose intervals.

Most of the deliveries (80%) take place at home. The survey cites in most of cases were in rural areas, thus this result was expected. IbnSina clinics provide only OPD services till 1 p.m., that is the reason for the very low number of deliveries at clinics.



More emphasis is needed for training of TBA's at community level, proper antenatal care and identification of cases at risk on time and referring to secondary obstetric care centers.

Relatives and un-trained TBA's provide most of the deliveries. Deliveries without skilled care are 61% according our survey results whereas it is 90% according to the national statistics.



Section IV

Maternal and Child Mortality

Maternal Mortality **2380/100,000 live births per year**
(UNICEF Afghanistan Situation Analysis 1997, MMR = 1700/100,000 live births)

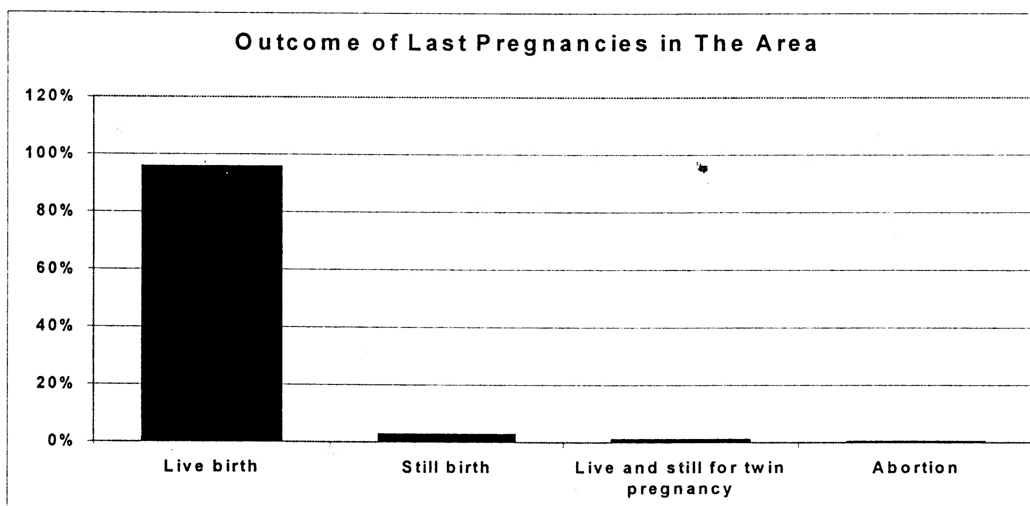
Infant Mortality **81/1000 live births per year**
(UNICEF Afghanistan Situation Analysis 1997, IMR = 182/1000 live births per year)

The mortality rates are very different from the available national figures. The MMR is about twice the national figure and the infant mortality is about two and a half times less.

The lowered infant mortality could be due to the fact that the respondents are from around the clinic; therefore the families have easy access and utilise the vaccination services and bring the children for early treatment of disease.

The clinic services do not include emergency obstetric care and referral to secondary level care remains as difficult as in any other area. However, there could also be errors in the defining maternal death in last one year and data collection that have resulted in the sharply different figures.

Outcome of the last pregnancy was live birth in most cases. Still birth and abortion are recorded in only few cases.



Finally, it must be recognized that the magnitude of the need for maternal and child health care is far greater than what is being provided. Also the need is increasing with the rapid growth of population, pregnancies and births. While efforts to provide more effective, efficient and equitable maternal and child health care services must continue, the progress can be enhanced with appropriate spacing of births and planning pregnancies at ages which are safe for motherhood as well as for the infant. Recognizing such health advantages, family planning is considered an integral part of maternal and child health care. Emergency obstetric services to decrease maternal mortality rate are may be one solution.

Recommendations

- Strengthening of mother and child health activities of IbnSina by capacity building of its staff.
- Inclusion of child spacing message in health education sessions
- Counseling of male partners on importance of child spacing specially adverse effects of frequent pregnancies on mother and child health
- Educate people regarding clinical methods of contraception and also their availability should be confirmed.
- Supply of wide range of contraceptives to all health facilities
- Further study on causes of high maternal mortality ratio
- Nurses are trained personnel conducting deliveries at home, have a background of mother care. This group also needs refresher training for safe delivery.
- To start emergency Obstetric services

Bibliography

Following documents were studied in the phase of planning and organizing of survey:

1. Pakistan contraceptive prevalence survey 1984-8
2. Reproductive health survey JAMAICA 1997
3. Semi-annual Progress report 1999 SCA in reproductive health and family planning (UNFPA) project
4. Indicators for population and reproductive health programs by UNFPA
5. Family planning handbook for field workers by Mrs. Imtiaz Kamal Ex-director country representative in Pakistan Pathfinder International, UNICEF
6. planning workshop on communication for polio eradication
7. EPI and surveillance in Afghanistan and community health surveys a practical guide for health workers

Reproductive Health Survey

April 20th to May 17th 2000

Survey Sites:

Nangarhar: *(Khewa, Shamshapoor, Amarkhail, Bagrami, Qasaba)*
Laghman: *(Charbagh)*
Wardak: *(Phrakhulum, Kot Ashro)*
Paktya: *(Gardez)*
Ghazni: *(Ghazni city, Tormai, Qarabagh, Moqor, Kakrak)*
Bamyan: *(Bamyan markaz, Kahmard)*
Parwan: *(Siagerd)*
Helmand: *(Greshk, Nauzad)*



Conducted by:



IbnSina Public Health
Program For Afghanistan

Funded by:



UNFPA United Nations Population Fund
P.O. BOX 1051, ISLAMABAD, PAKISTAN

Table of Contents

Acknowledgement

We wish to record our appreciation and thanks for the valuable assistance given by several individuals who contributed in the planning and conducting this reproductive health survey.

We are thankful to Dr. Anwarulhaq Jabarkhail, Director General of IbnSina, for his moral support and encouragement. We acknowledge the contribution of staff of the technical department of IbnSina, especially Dr. Mirza Jan, Technical Manager and Dr. Panna Erasmus, Technical Advisor for their collaborative discussion and consultation. We also thank operation and finance departments for their full support.

This account will be incomplete without recognizing the contribution and honest work of IbnSina's staff of regional offices and health facilities who spared no effort in the implementation of this survey.

We express our sincere and heartfelt gratitude to UNFPA for providing funds that enabled us to conduct reproductive health survey.

Finally, we convey our thanks to the Regional Public Health Presidency and the local authorities for providing clearance and support during implementation of survey.

HIS Section,
Technical Department, IbnSina
January, 2001

Executive Summary

IbnSina conducted a baseline survey in the catchment area of its 19 MCH clinics between April 20th to May 17th 2000. The main purpose of the survey was to collect information on the health status of women of childbearing age and the level of current users of family planning methods. Moreover, factors affecting contraceptive prevalence were evaluated.

Women were chosen from houses nearest to the clinic for convenience. On average 30 women of childbearing age were selected from each clinic catchment area. 573 married women were interviewed during two days of field survey. 19 teams, each comprising two female surveyors conducted the survey.

The survey results showed a literacy rate of 18.2% for women at childbearing age. The maternal mortality was very high, while infant mortality was low. Most of the women were in favor of child spacing for more than two years. More than half of the women were using either clinical or conventional family planning methods.

Maternal Mortality **2380/100,000 live births per year**
(UNICEF Afghanistan Situation Analysis 1997, MMR = 1700/100,000 live births)

Infant Mortality **81/1000 live births per year**
(UNICEF Afghanistan Situation Analysis 1997, IMR = 182/1000 live births per year)

The mortality rates are very different from the available national figures. The MMR is about twice the national figure and the infant mortality is about two and a half times less.

The lowered infant mortality could be due to the fact that the respondents are from around the clinic; therefore the families have easy access and utilise the vaccination services and bring the children for early treatment of disease.

The clinic services do not include emergency obstetric care and referral to secondary level care remains as difficult as in any other area. However, there could also be errors in the defining maternal death in last one year and data collection that have resulted in the sharply different figures.

Marital General Fertility Rate (MGFR) 436 live birth per1000

The survey did not collect age specific birth rates. Therefore, it was not possible to calculate the total fertility rate. However, the MGFR is twice that of Pakistan's in 1984-1985. The total fertility rate for that period in Pakistan was 7.73. The TFR for the sample of women should therefore be about twice that of Pakistan. The average number of children in a family is five with ideal of seven.

Proportion of women currently using clinical methods of contraception	**27%**
Proportion of women currently using natural methods of contraception	**21%**
Proportion of women who acquire contraceptives from the Clinics	**60%**

Pills constituted the highest proportion of clinical contraceptives. In natural methods breast feeding as a methods of contraception was commonly practiced. The main source of supply of contraceptives was health facilities.

Many women were aware of pills and injections, and were able to cite them as methods of contraception without prompting. Fewer women were able to cite IUCDs and condoms as contraceptives. With prompting, the numbers of women who recognized these methods rose, with a higher rise in those who recognized the surgical methods of contraception. At the time of the survey, IbnSina clinics provided pills, injections and condoms as FP methods. The unprompted knowledge would seem to be linked with the methods that were currently available. Surgical methods were previously available in Afghanistan and the rise in prompted knowledge would indicate familiarity with this method from previous times or from migration experiences.

Withdrawal is accepted in Islam and is practiced by a proportion of the people. The fact that breast feeding protects against pregnancy, seems to be known to some of the women and practiced. The issue of the type of breast feeding, e.g. full breast feeding was not explored. The fact that shortly after start of menstrual cycle after delivery, the risk of pregnancy increases needs to be brought out in education and mobilisation.

Major cause of discontinuatiion of contraceptives were disapproval by husbands (52%). Other major causes being doctors recommendation, forgot to use it and health poblems.

Major reasons for not using any family planning methode amongst the women surveyed were current pregnancy (30%), desire for having more children (25%), breast feeding child (11%) and religious believes (9%).

Proportion of women feel 1 to 2 years is ideal space	**21.6%**
Proportion of women feel 2 years or plus is ideal space	**56.9%**

56.9% of women feel 2 years or plus is the ideal space between children. Only 27% use clinical methods and 21% use natural methods. This difference indicates a potential demand and the need to make these services more widely available and known.

Finally, it must be recognized that the magnitude of the need for maternal and child health care is far greater than what is being provided. Also the need is increasing with the rapid growth of population, pregnancies and births. While efforts to provide more effective, efficient and equitable maternal and child health care services must continue, the progress can be enhanced with appropriate spacing of births and planning pregnancies at ages which are safe for motherhood as well as for the infant. Recognizing such health advantages, family planning is considered an integral part of maternal and child health care. Proper antenatal, natal and post natal care, training and follow up of TBA,s and emergency obstetric services may be the solutions to decrease maternal mortality rate.

Introduction

Afghanistan's health infrastructure has been destroyed in the aftermath of more than 20 years consecutive war. The poverty and lack of health services resulted in deteriorating health of Afghan people and the impact has been worst in the most vulnerable groups of community, the children and women in the reproductive age.

Health statistics study in national level in Afghanistan carried out by UNDP in 1996 and UNICEF Afghanistan situation analysis 1997 is:

Maternal mortality rate is	**1700 per 100,000 live births**
Infant mortality rate	**182 per 1000 live births**
Under five mortality rate	**250 per 1000 live births**
Fertility rate	**6.9**
Birth rate	**5%**
Deliveries without skilled care	**90%.**

Restrictions on women's movement and employment have reduced the number of trained female staff available and directly have affected the health of vulnerable groups.

Our MCH clinic staff are able to deliver necessary maternal and child health services. However for the provision of good quality services, the skills of both medical doctors and mid level health workers were in need of upgrading. The provision of appropriate equipment and contraceptives is essential. IbnSina's project proposal addressed both the issues of training and supply in the plan to strengthen reproductive health services.

Reproductive health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and process. Reproductive health therefore implies people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Family planning means to plan a family, to decide the number of children a couple wants, to decide on the interval between two pregnancies and to use a suitable method to postpone unwanted pregnancy.

There was no survey or document available in regard to family planning in Afghanistan. Although most stakeholders in Afghanistan provide the service, but still to our information a baseline information is never collected. We hope this survey may provide some basic information about the health status of women of child bearing age and the issue of family planning and provide some baseline information that could help us to evaluate our services in strengthening reproductive health services.

Survey Objectives

- To collect information on the health status of women at child bearing age.
- To collect information on the level of current uses of family planning in our MCH clinics catchment area
- To gather information on the factors that effect the contraceptive prevalence rate
- To use the information for planning strategies to enhance acceptance and continuation of use of family planning
- To use the information as a baseline for future surveys

Methodology

Regional and District authorities and MOPH were informed and written permission for conducting the survey was taken.

Women were chosen from houses nearest to the clinic for convenience. On average 30 married women at childbearing age (15-45) were selected from each clinic catchment area. 573 married women were interviewed during two days of field survey. One woman per household was interviewed.

19 teams, comprising two female surveyors conducted the survey. Both surveyors were selected from the clinic staff. The survey was done after clinic working hours. Surveyors were trained in survey methodology, basic concept of survey and filling of questionnaire. A summary report of each site was made and sent to the Main Office for analysis.

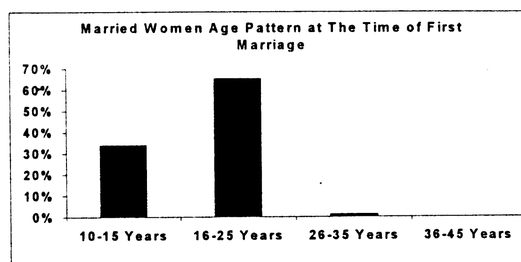
Pilot test of survey questionnaire was done in Bagrami MCH clinic of Nangarhar region.

Limitations/ Biases

- The methodology was convenient.
- Study unit was from houses near the clinic.
- Only locations with IbnSina MCH health facility were included in the survey.
- The result will not represent the whole country.
- "Last one year" for maternal mortality was not well defined
- The total fertility rate was not possible to estimate because information was not collected on number of live births by age category.
- "Number of TT vaccines taken for last pregnancy" was not well defined

Survey Results

A summary report of each site was made to compile the data and then were sent to the Main Office for analysis. An average of 30 women were interviewed in each clinic catchment area. The total number of respondents were 573 married women of child bearing age.



More than 94% of the respondents were married between 10-25 years of age. More than 32%are married at the age of 15 or less than that. It indicats that a potential group with high risk pregnancy and infant and maternal mortality exists in the community.

Only 18% of the respondents were literate. 54% had primary education, 37.5% secondary education and 8.6% university education. The literacy rate doesn't show any significant relation with average age of marriage.

Table 1: Relation between average age at the time of first maariage and literacy rate

Regions	Central	East	South east	South west	All
Average	17	16	18	17	**17**
Literacy rate	14%	13%	22%	18%	**18%**

The survey results are categorised in four sections. In section one we will talk about the fertility followed by contraceptive prevalence and maternal care at section two and three and maternal and infant mortalility rate at section four.

Section I Fertility

Fertility rate

General fertility rate is the number of live birth in a year in an area by mid year female population (15-44) in the same area in 1000. Fertility is the major contributor of the high population growth rate.

The survey did not collect age specific birth rates. Therefore, it was not possible to calculate the total fertility rate. **However, Marital General Fertility rate is measured 436 live birth/1000 married women.** The MGFR is twice that of Pakistan's as conpared with 1984-1985 contraceptive prevalence survey. The total fertility rate for that period in Pakistan was 7.73. The TFR for the sample of women should therefore be about twice that of Pakistan. This high level of fertility are cause of major concern. High fertility is a feature of many traditional societies where children are viewed as potential producer of income and a source of support in old age.Mainly parents desire a large family and, in particular sons.

Pregnancy rate

To determine pregnancy rate, total number of currently married women of childbearing age interviewed or the number of married women in the household can be used as denominator. **The pregnancy rate was 164 per 1000 women at childbearing age**. As compared with Pakistan contraceptive prevalence survey, it shows the same result.

Ideal number of children

On average an Afghan woman desires 7 children. The mean of the number of alive children whether they live with the family or not was 5. It means each family desires for another two children. This needs counseling with the women to space their children and have limited number of children.

Desire for child spacing

It is apparent that most of the women are in favor of child spacing for more than 2 years. Thus, a significant proportion is potential candidate for use of contraceptives. If different factors obstructing the use of child spacing method is looked at and a strategy is planned, then it is possible to increase the contraceptive prevalence. . Islamic and social factors should also be analyzed and discussed. One major issue is to convince the husbands on health hazards of too many and too frequent child bearing by women

Table 2: Desire for child spacing

Desire for child spacing	Frequency	Relative Frequency
Within one year (seeking pregnancy now)	31	9.5%
After one but before two years	70	21.6%
After two years	184	56.9%
Whenever it happens	21	6.5%
It depends to different factors	17	5.2 %

Section II Contraceptive

Contraception is practiced from ancient times. Muslims practiced it during early days of Islam. The practice of contraception is for wellbeing of not only mothers and children but the whole family. In this section information regarding contraceptives knowledge, practice and opinion is collected. Moreover, the obstacle for use of contraceptives were also identified.

Contraceptive Awareness and knowledge

Information on awareness and knowledge of contraceptives amongst the married women in the reproductive age was collected in two steps. First without prompting the information on the knowledge was collected and then the prompted knowledge was judged.